		H AND HUMAN SERVICES	×.		OMB NO.	0938-0391
		E & MEDICAID SERVICES	IAS/ MID.	TIPLE CONSTRUCTION	(X3) DATE SI	JRVEY
TEMEN I DPLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDËR/SUPPLIËR/CLIA IDENTIFICATION NUMBER:	A. BUILDI	•	COMPLETED	
			IV. POSEDI			C
	•	085033	B. WING		04/0	5/2012
VE 00 00	ROVIDER OR SUPPLIER		1 2	TREET ADDRESS, CITY, STATE, ZIP C	ODE	
				5651 LIMESTONE ROAD	•	ł
ANORC	ARE HEALTH SER	RVICES - PIKE CREEK		WILMINGTON, DE 19808		
	01111111111111111111111111111111111111	TATEMENT OF DEFICIENCIES	, <u> </u>	PROVIDER'S PLAN OF C	ORRECTION	(X5) COMPLETION
(X4) ID   PREFIX	かいんり ひばりんけん	CV MHST RE PRECEDED BY FULL (	PREFIX	(EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH	ON SHOULD BE OF APPROPRIATE	DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY	) .	<i>'</i>
· ,		X		-		
		ren .	F-00	مهمین أ (١٥	on this plan	
F 000	INITIAL COMME	NIS i	1 00	I he statements made	Off this brane	
·				of correction are not	an	
	An unannounced	i annual and complaint survey		admission to and do	not	
·	was conducted a	t this facility from March 28,		constitute an agreem	ent with the	1
• 4	2012 through Ap	ril 5, 2012. The deficiencies		alleged deficiencies	herein.	
	contained in this	report are based on		alleged devictorion		
	observations, into	erviews, review of resident's		31	a with all	
	clinical records a	nd review of other		To remain in compl	ISDGE Mim on	
	documentation a	s indicated. The facility census		colours and state reg	manons, uic	
	the first day of th	e survey was 150. The survey	ĺ	Castifer has taken of	will take the	
	sample included	forty (40) census sample	ļ	actions set forth in	he following	
	residents and in	irty (30) admission sample	1	actions set total m	The	
	residents in Stay	ge I. The Stage II sample totaled		plan of correction.	1110	
	thirty eight (38) r		F 2	following plan of c	OTTECTION	
F 225		(III), (C)(Z) - (4)	-	constitutes the fact	lity's	4
SS=D	INVESTIGATE/I	MERUNI MANUMUNIAI S	Ì	allogation of comp	liance such	
	ALLEGATIONS	MADIVIDO: CO	ļ	ted dependent of the transfer	iciencies cheu	
	The facility must	t not employ individuals who have		have been or will h	e corrected by	
	hoen found quili	y of abusing, neglecting, or		have been or will to	dianted	
-	micfreating resid	dents by a court of law; or have	1	the date or dates in	idicated.	
	had a finding er	ntered into the State nurse aide				
	registry concert	ning abuse, neglect, mistreatment	1			ı
	i of residents of t	misappropriation of their property;				
	and report any	knowledge it has of actions by a	:	1	•	
	court of law aga	ainst an employee, which would	1			
	indicate unitine	ss for service as a nurse aide or	1			1
	other facility sta	aff to the State nurse aide registry		. !		i 荒し
-	or licensing aut	horities.	· }		•	Į.
			•	ļ		ļ
	The facility mus	st ensure that all alleged violations	•			ļ
	involving mistre	eatment, neglect, or abuse,		•		į
	including injurie	es of unknown source and	-1 -1			į
	misappropriation	on of resident property are reporte	4   4	ļ		
	immediately to	the administrator of the facility and	u '	į ·		ļ
	to other official	s in accordance with State law		,		ī
	through establ	ished procedures (including to the	! !			i
	State survey a	nd certification agency).	•	•		
			<u> </u>	The second secon		(XB) DATE,
LABORAT	ORY PECTOR'S OR P	POVINE ISUPPLIER REPRESENTATIVE'S	SIGNATURE	א ולל"א		71.
(	111/2 . 1 1	1888 1 5 1 61 B	n ,	<i>IV ++ /+</i>		<u> </u>
	<del>/                                    </del>	g with an esterisk (*) denotes a deficiency	which the i	nstitution may be excused from com-	ecting providing it is	determined that
Any defic	iencylstatement ending	g with an esterisk (*) denotes a feficiency ent protection to the patients. (See instruc	tions.) Exc	cept for nursing homes, the findings	stated above are dis-	closable 90 days
oulet sate	the date of survey who	ent protection to the patients. (See instruction of the provided of the provided of the provided of the facility of the facili	1 For nursi	ing homes, the above findings and p	correction is requisit	to continued
days folic	owing the date these o	ether or not a plan of correction is provided ocuments are made available to the facility	у. и фетісіе	incles are circu, an approved plan of		
program	participation.					<b></b>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: A08Z11

Facility ID: DE00145

If continuation sheet Page 1 of 14

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FICIENCIES RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	085033	B. WING _		04/05/201	2
		5	651 LIMESTONE ROAD		
EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE COMP	X5) LETION ATE
facility must I tions are thorent further postigation is in results of all le administrates entative an State law (indication agent ent, and if the opriate corresponded to record the to complete sequently faile 284) out of 3	nave evidence that all alleged roughly investigated, and must obtential abuse while the progress.  Investigations must be reported or or his designated d to other officials in accordance cluding to the State survey and cy) within 5 working days of the e alleged violation is verified ctive action must be taken.  ENT is not met as evidenced review and interview, it was ne facility failed to identify a tial resident to resident abuse, is allegation to the State agency, a thorough investigation and ed to submit a 5 day follow up for	F 225	Allegations/Individuals. It is the practice of the facthat all alleged violations involving mistreatment, no or abuse, including injurie unknown source and misappropriation of reside property are reported immediately to the adminion of the facility and to other officials in accordance with law through established procedures.  It is the practice of the face	eglect, s of ent strator th State	16/12
noses of Alzh gestive heart nonary diseas ew of the Sig (MDS), dated t and long ter erely impaired sion making. equiring exter	neimer's Disease/dementia, failure, and chronic obstructive se.  Inificant Change Minimum Data 5/15/11, coded R284 as having rm memory loss and being d in cognitive skills for daily Additionally, R284 was coded asive assistance of two persons		the facility to prevent furth potential abuse while the	her	
	ER OR SUPPLIEF  HEALTH SEF  SUMMARY S (EACH DEFICIEN REGULATORY OF STEED AT THE PROPERTY OF STEE	DENTIFICATION NUMBER:  085033  ER OR SUPPLIER  HEALTH SERVICES - PIKE CREEK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  tinued From page 1 facility must have evidence that all alleged ations are thoroughly investigated, and must rent further potential abuse while the stigation is in progress.  results of all investigations must be reported be administrator or his designated resentative and to other officials in accordance State law (including to the State survey and dification agency) within 5 working days of the dent, and if the alleged violation is verified repriate corrective action must be taken.  REQUIREMENT is not met as evidenced sed on record review and interview, it was extrained that the facility failed to identify a lation of potential resident to resident abuse, and to report this allegation to the State agency, do to complete a thorough investigation and sequently failed to submit a 5 day follow up for 1284) out of 38 Stage II sampled residents.	RECTION   DENTIFICATION NUMBER:   A. BUILDIN   B. WING   D85033   B. W	ERCOTION DENTIFICATION NUMBER:  085033  BROWNE  BEALTH SERVICES - PIKE CREEK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Through From page 1 facility must have evidence that all alleged titions are thoroughly investigated, and must ent further potential abuse while the stigation is in progress.  Tesults of all investigations must be reported ea administrator or his designated esentative and to other officials in accordance State law (including to the State survey and fincation agency) within 5 working days of the lent, and if the alleged violation is verified repriate corrective action must be taken.  REQUIREMENT is not met as evidenced sed on record review and interview, it was irrnined that the facility failed to identify a ation of potential resident to resident abuse, do report this allegation to the State agency, do report this allegation to the State agency, do to complete a thorough investigation and sequently failed to submit a 5 day follow up for 2244) out of 38 Stage II sampled residents. lings include:  4 was admitted to the facility on 4/19/11 with noses of Alzheimer's Disease/dementia, gestive heart failure, and chronic obstructive nonary disease.  iew of the Significant Change Minimum Data (MDS), dated 5/15/11, coded R284 as having a rely impaired in cognitive skills for daily significant making. Additionally, R284 was coded equiring extensive assistance of two persons	RECTION  DENTIFICATION NUMBER:  085033  STREET ADDRESS, CITY, STATE, ZIP CODE SSST LIMESTONE ROAD WILMINGTON, DE 19808  SUMMARY STATEMENT OF DEPCIENCIES (EACH DERFICIENCY MUST BE RECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION)  FREETY TAGS  FROMDERS PLAN OF CORRECTION (EACH DERFICIENCY MUST BE RECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION)  FREETY TAGS  PROVIDERS PLAN OF CORRECTION (EACH ORNECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  FY225 — Investigate/Report Allegations/Individuals.  It is the practice of the facility that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures.  It is the practice of the facility to maintain evidence that all alleged violations are thoroughly investigation and sappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures.  It is the practice of the facility to maintain evidence that all alleged violations are thoroughly investigated and the practice of the facility to prevent further potential abuse while the investigations are in process.

NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES - PIKE CREEK    X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   FREERIX   TAG   SUMMARY STATEMENT OF DEFICIENCIES   FREERIX   FREEDULATORY OR I.SCI DENTIFYING INFORMATION,   TAG   PROVIDER'S PLAN OF CORRECTION   FREERIX   TAG   PROVIDER'S PLAN OF CORRECTION   PREERIX   TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION   PREERIX   PROVIDER'S PLAN OF CORRECTIVE ACTION   PREERIX   TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION   PREERIX   TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION   PROVIDER'S PLAN OF CORREC	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MANORCARE HEALTH SERVICES - PIKE CREEK    CAP ID   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG     F 225   Continued From page 2   Review of the Nurses' Notes for R284, dated 6/23/11 at 6:00 AM, revealed, "Pt A/O (patient alert and oriented) no s/s (signs/symptoms) of bruising noted as roommate (Resident who chose to be antonymous) states that the third roommate (R195) was hitting him (R284) while in bed, because he (R195) c/o (was complaining) he (R284) was making noise patient (R284) removed out of the room will continue to monitor."  The resident who chose to be anonymous was coded on an admission MDS, dated 5/10/11, as being alert and oriented with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. On 3/29/12 this anonymous resident in an interview stated that the observed that R195 was at R284's bed side and heard R284 state that R195 was hurting his eye.  On 4/5/12, in an interview with E16 (Nurse), she stated that the resident who reported the event told her that R195 was hitting R284, E16 stated that who entered the room to give medications and the three residents were in bed. E16 stated that was when the anonymous resident told her of the above statement. Despite the anonymous resident to being an alert and oriented resident, E16 (blook of the stated that and oriented resident, E16 (blook of the stated that manolymous resident to long the resident state when the anonymous resident to report the results of all investigations to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident and if the alleged violation is verified appropriate corrective action is taken.  Resident #284 no longer resident will be audited for evidence of documentation of alleged resident to resident state will be audited for evidence of documentation of alleged resident to resident state that whe resident to the anonymous resident to resident state that the resident state			·			С	
MANORCARE HEALTH SERVICES - PIKE CREEK    SUMMARY STATEMENT OF DEFICIENCIES   PREPIX TAG   PROPRIETS PLAN OF CORRECTION   PREPIX TAG   PROPRIETS PLAN OF CORRECTION   PREPIX TAG   PROPRIETS PLAN OF CORRECTION   PREPIX TAG   PROPRIETS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    F 225   Continued From page 2     F 225   It is the practice of the facility to report the results of all investigations to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident and if the alleged violation is verified appropriate corrective action is taken.    The resident who chose to be anonymous was coded on an admission MDS, dated \$6/10/11, as being alert and oriented with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. On 3/29/12 this anonymous resident in an interview, stated that he observed that R195 was at R284's bed side and heard R284 state that R195 was hurting his eye.    On 4/5/12, in an interview with E16 (Nurse), she stated that the resident who reported the event told her that R195 was hitting R284. E16 stated that she entered the room to give medications and the three residents were in bed. E16 stated that was when the anonymous resident told her to bove statement. Despite the anonymous resident being an alert and oriented resident, E16 elected that red did not do a plantified resident, E16 elected that red did not do a plantified resident, E16 elected that red did not do a plantified resident, E16 elected that red did not do a plantified resident, E16 elected that red did not do a plantified resident, E16 elected that red did not do a plantified resident for evidence of documentation of alleged resident or or designee will inservice employees on identifying elected that red did not do a plantified resident, E16 elected that red did not do a plantified resident, E16 elected that red did not do a plantified resident for evidence of documentation of alleged resident or or design			085033	B. WING _		04/0	)5/2012
F225 Continued From page 2  Review of the Nurses' Notes for R284, dated 6/23/11 at 6:00 AM, revealed, "Pt A/O (patient alert and oriented) no s/s (signs/symptoms) of bruising noted as roommate (Resident who chose to be antonymous) states that the third roommate (R195) was hitting him (R284) while in bed, because he (R195) c/o (was complaining) he (R284) was making noise. patient (R284) removed out of the room will continue to monitor."  The resident who chose to be annonymous was coded on an admission MDS, dated 5/10/11, as being alert and oriented with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. On 3/29/12 this anonymous resident in an interview, stated that he observed that R195 was at R284's bed side and heard R284 state that R195 was hitting R284. E16 (Nurse), she stated that the resident who reported the event told her that R195 was loud of bed and thought that R195 was hitting R284. E16 stated that was when the anonymous resident told her of the above statement. Despite the anonymous resident to resident abuse on identifying the service employees on identifying the coordinator or designee will inservice employees on identifying				5	651 LIMESTONE ROAD	DE	
Review of the Nurses' Notes for R284, dated 6/23/11 at 6:00 AM, revealed, "Pt A/O (patient alert and oriented) no s/s (signs/symptoms) of bruising noted as roommate (Resident who chose to be antonymous) states that the third roommate (R195) was hitting him (R284) while in bed, because he (R195) c/o (was complaining) he (R284) was making noise. patient (R284) removed out of the room will continue to monitor."  The resident who chose to be anonymous was coded on an admission MDS, dated 5/10/11, as being alert and oriented with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. On 3/29/12 this anonymous resident in an interview, stated that he observed that R195 was at R284's bed side and heard R284 state that R195 was hurting his eye.  On 4/5/12, in an interview with E16 (Nurse), she stated that the resident who reported the event told her that R195 was out of bed and thought that R195 was hitting R284. E16 stated that was when the anonymous resident told her of the above statement. Despite the anonymous resident being an alert and oriented resident, E16 stated that the resident who reported the event told her batch the type did not be anonymous resident told her of the above statement. Despite the anonymous resident being an alert and oriented resident, E16 stated that was when the anonymous resident told ner of the above statement. Despite the anonymous resident being an alert and oriented resident, E16 stated that was when the above statement. Despite the anonymous resident being an alert and oriented resident, E16 stated that was when the above statement. Despite the anonymous resident being an alert and oriented resident, E16 stated that was when the above statement. Despite the anonymous resident being an alert and oriented resident, E16 stated that was when the above statement. Despite the anonymous resident being an alert and oriented resident, E16 stated that was when the above statement. Despite the anonymous resident to the oriented resident, E16 stated that was when the above statement.	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	! SHOULD BE	COMPLETION
because when she went into the room, there was no evidence that R195 was out of bed and she did not feel it was necessary. Also, E16 stated that she passed on the information about the "incident" in report to the next shift but did not remember to whom.  On 4/4/12, in an interview with E6 (RN/Director of	F 225	Review of the Nu 6/23/11 at 6:00 A alert and oriented bruising noted as to be antonymous (R195) was hitting because he (R19 (R284) was making removed out of the The resident who coded on an admit being alert and or Interview of Ment On 3/29/12 this a interview, stated at R284's bed sid R195 was hurting On 4/5/12, in an instated that the restold her that R195 that R195 was hit entered the room three residents when the anonymabove statement, resident being an stated that she did because when show evidence that did not feel it was that she passed of "incident" in reportemember to who	Arses' Notes for R284, dated M, revealed, "Pt A/O (patient) no s/s (signs/symptoms) of roommate (Resident who chose is) states that the third roommate is him (R284) while in bed, is c/o (was complaining) he ing noise. patient (R284) he room will continue to monitor."  I chose to be anonymous was ission MDS, dated 5/10/11, as riented with a BIMS (Brief al Status) score of 15 out of 15. Inonymous resident in an ithat he observed that R195 was in early and heard R284 state that if his eye.  Interview with E16 (Nurse), she is dent who reported the event is was out of bed and thought itting R284. E16 stated that was mous resident told her of the Despite the anonymous alert and oriented resident, E16 d not do an incident report he went into the room, there was R195 was out of bed and she increasely. Also, E16 stated on the information about the it to the next shift but did not om.	F 225	report the results of all investigations to the administrator or his desirepresentative and to oth officials in accordance velaw within 5 working daincident and if the alleg violation is verified appropriate action is taken.  Resident #284 no longer at the facility.  Nurses' notes of current rewill be audited for evider documentation of alleged resident to resident abuse through April 5, 2012.  The Staff Development Coordinator or designee service employees on idea and reporting alleged resident abuse.	ignated her with State ays of the ed oropriate en. er resides residents nce of l e back will in- entifying	5/1/2

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		085033	B. WIN	·		04	04/05/2012	
	PROVIDER OR SUPPLIER  CARE HEALTH SER	/ICES - PIKE CREEK		565	ET ADDRESS, CITY, STATE, ZIP CODE 61 LIMESTONE ROAD LMINGTON, DE 19808		:	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 225	Care Delivery), he of any resident to rand R195. Also, Ed the incident reports there were any issuproblems/abuse.  The facility failed to resident abuse, fail a thorough investig 5 day follow up. Or (Director of Nursing E16 should have dit should have beer 483.15(h)(2) HOUS MAINTENANCE Since The facility must promaintenance service sanitary, orderly, at This REQUIREME by:  Based on observation of Find the facility failed and maintenance is a sanitary and order of the facility failed and maintenance is a sanitary and order on the frames of the facility of the facility failed and maintenance is a sanitary and order on the frames of the facility failed and maintenance is a sanitary and order on the frames of the facility failed and maintenance is a sanitary and order on the frames of the facility failed and maintenance is a sanitary and order on the frames of the facility failed and maintenance is a sanitary and order on the frames of the facility failed and maintenance is a sanitary and order of the facility failed and maintenance is a sanitary and order of the facility failed and maintenance is a sanitary and order of the facility failed and maintenance is a sanitary and order of the facility failed and maintenance is a sanitary and order of the facility failed and maintenance is a sanitary and order of the facility failed to the facil	stated that he was not aware esident issues between R284 is stated that he receives all of a so that he would be aware if uses of resident to resident to ed to report, failed to complete ation and incident report and that one an incident report and that in investigated.  SEKEEPING & ERVICES  Tovide housekeeping and complete interior.  Note in the provide housekeeping and comfortable interior.  Note in the provide housekeeping and comfortable interior.  Note in the provide housekeeping and and comfortable interior.  Note in the provide housekeeping and and the provide housekeeping and a services necessary to maintain and the provide housekeeping and the provide housekeeping are provided to provide housekeeping and the provide housekeeping are provided to provide housekeeping and the provided housekeeping are provided to provide housekeeping are provided and provided to provide housekeeping are provided to provide housekeeping are provided to provide housekeeping are provided to provided t		225	The Staff Development Coordinator or designee will service licensed nurses on reporting and completing a thorough investigation and of timely submission to the Di of Long Term Care Residen Protection.  The Administrative Director Nursing has in-serviced employee E-16 on the prop guidelines for reporting allor resident to resident abuse.  The Administrative Director Nursing or designee will complete random weekly aut for three months of nurse's in daily morning meeting.  The Administrative Director Nursing or designee will complete random weekly aut for three months to evaluate timely submission of incider  Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and a	on the vision ats or of er eged r of adits notes r of the adits the ats.	5/14/	
ORM CMS-2	l 567(02-99) Previous Version	s Obsolete Event ID: AO8Z11		Fe	as appropriate. The Quality Assessment and Assurance	– h	eet Page 4 of 14	

Committee will determine the need for further audits and/or

action plans.

PRINTED: 04/16/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRU A. BUILDING			(X3) DATE SURVEY COMPLETED	
		085033	B. WIN			C <b>04/05/2012</b>	
*	PROVIDER OR SUPPLIER	VICES - PIKE CREEK	•	565	ET ADDRESS, CITY, STATE, ZIP CODE 51 LIMESTONE ROAD ILMINGTON, DE 19808		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323 SS=E	2. Observation of shower room on the there was food debottom of the Star On 4/5/12, in an interpretation of the Star On 3/28/12 are shower to the facility must be environment remains as is possible; and adequate supervisity prevent accidents.  This REQUIREMENT of the facility failed to the fa	a Stand-Up lift in the central he Arcadia unit revealed, that bris and encrusted dirt on the hid-Up lift.  Interview with E1, E10 and E11, a findings.  DF ACCIDENT RVISION/DEVICES  Insure that the resident hazards a each resident receives sion and assistance devices to actions and staff interviews, it hat the facility failed to maintain the ancillary, oxygen and mechanical rooms are survey as follows:  The Arcadia unit revealed, that the review of accident hazards when a maintain the receives and mechanical rooms are survey as follows:  The Arcadia unit revealed, that the findings include:		323	F253 – Housekeeping and Maintenance Services It is, the practice of this facili provide housekeeping and maintenance services necess to maintain a sanitary, order and comfortable interior.  R271, R226 and R22 whee have been cleaned.  The stand-up lift on the Arr Unit has been cleaned.  The Maintenance and Housekeeping Directors has completed environmental to evaluate whether the fact maintaining an orderly and sanitary interior.  The Staff Development Coordinator or designee will service staff on identifying a communicating environment concerns.  The Maintenance Director and Housekeeping Director or designee will perform randoweekly audits for three months.	sary rly, lchairs cadia  ave rounds cility is l l in- and tal and tal om ths.	5/1/12
	umerent surveyors	s observed the door to the			Results of these audits will forwarded to the Quality	be 	

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Event ID: AO8Z1

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sheet Page 5 of 14

Assessment and Assurance

Committee for review and action as appropriate. The committee will determine need for further audits and/or action plans.

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLIER/CLIA (X4) MULTIPLE CONSTRUCTION (X5) DATE SUPPLIER/CLIA (X6) MULTIPLE CONSTRUCTION (X6) DATE SUPPLIER/CLIA (X6) MULTIPLE CONSTRUCTION (X7) DATE SUPPLIER/CLIA (X7) MULTIPLE (X7) MULTI					
		085033	B. WING		t	5/2012
	ROVIDER OR SUPPLIER	VICES - PIKE CREEK	56	EET ADDRESS, CITY, STATE, ZIP CODE 651 LIMESTONE ROAD //ILMINGTON, DE 19808		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F.323	Oxygen tank stora unlocked and acce which posed a pote of the posed a	ge room on the Linden Hall, essible to residents and visitors ential accident hazard.  Inding was confirmed by E14 was able to open the door combination. She stated that in there, did not ensure that the I the way shut. Consequently, ich.  In the way shut consequently, ich.	F 323	F323 – It the practice of this facility to ensure that the resident's environment remarked free of accident hazards as it possible; and each resident receives adequate supervision and assistive devices to prevaccidents.  The facility immediately platemporary pad locks on the ancillary, oxygen storage are utility rooms. The employed in-serviced on making sure the mechanical door room blocked at all times.  Electric wheelchairs are not longer being charged in half Equipment has been moved one side of the hallway on unit.  An audit of the electric wheelchairs was completed evaluate that charging was performed in the appropriate area.	ains s on vent aced ad ee was that is dlways. d to each	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
•		085033	B. WIN	1G			C 1/05/2012	
	ROVIDER OR SUPPLIER	VICES - PIKE CREEK		565	ET ADDRESS, CITY, STATE, ZIP CODE 11 LIMESTONE ROAD LMINGTON, DE 19808			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		OULD BE	(X5) COMPLETION DATE		
F 323	unlocked and acce (nurse) was asked was able to open a the door locking. Flocked. Again, this hazard.  This was confirme  2. During the initia multiple observation second floor of equivalent for resides of the hallwas impediment for resides.	age 6 essible to residents. E15 to try to open the door. E15 and shut the door twice without inally, on the third try, the door posed a potential accident  d with E15 (nurse).  tour, on 3/28/12, there were ans by two surveyors on the uipment being stored on both y, posing a potential idents to be able to travel on one side as follows:	F	323	An audit was completed evaluate that facility equivas on only one side of thallway.  The Housekeeping Directed designee will complete rative weekly audits for three methe ancillary, oxygen stora utility and mechanical rootensure that electric wheele are charged in the appropriarea and equipment is storonly one side of the hallward.	or or or or ondom onths of ones to chairs iate red on		
	equipment was sto observations including was stored between side of the hall - or Room 228 and a laparked past the exportant of Room 227.  B. On 3/28/12 at 8 observed with equipment the hall - this including the hall - this including charging in the hall outside of Room 2 other side of this highest part of the storage door to the During an interview	in a red emergency outlet 18 and a meal cart; on the all was observed a geri chair 13-214, a linen cart outside Range wheelchair with oxygen it door by the window, outside a signal and a meal cart; on the all was observed a geri chair 13-214, a linen cart outside re lift outside Room 212, and a per scale parked in front of a cart of the central bath.			The Staff Development Coordinator or designee was service staff on locking are oxygen storage, utility and mechanical rooms at all ticharging electric wheelches appropriate locations, and all equipment on only one the hallway.  Results of these audits will forwarded to Quality Asse and Assurance Committee review and action as appropriate to the committee will determine the for further audits and action plans.	mes, airs in storing side of lbe essment opriate.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		085033	B. WING _			5/2012
	ROVIDER OR SUPPLIER	ICES - PIKE CREEK	5	REET ADDRESS, CITY, STATE, ZIP CODE 651 LIMESTONE ROAD VILMINGTON, DE 19808	•	·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	side of the hall. Sh	ent in Room 215 on the other e confirmed the finding and wheelchairs were supposed to	F 323			
	observed with equi- hall: observations in (equipment used to hall across the hou- chair with wheels be linen cart and stand Rooms 207-208. Observed a geri cha- wet floor sign lying wheels just before there was a meal c 202-203. Again, th	25 AM, Yorklyn Hall was oment on both sides of the included a metal dolly move items) parked in the sekeeping door, a specialized etween Rooms 209-210, a dup scale parked between on the other side of the hall of and the Exit door was air, wheelchair and a caution flat on the floor in front of the the exit door. Additionally, art parked between Rooms is posed a potential dents to be able to travel on one side.				
F 371 SS=D	wheelchair was obs Kennett hall using to outside of Room 2°. The wheelchair was hallway which pose should have been of approved by the fire 483.35(i) FOOD PF	s incorrectly charged in the ed an accident hazard and charged in a safe area e marshall.	F 371	F371 –Food Procure, Store/Prepare/Serve-Sanita It is the practice of the facilit store, prepare, distribute, and serve food under sanitary conditions.		
		om sources approved or story by Federal, State or local		The Administrative Director of Nursing in-serviced E21 on proper hand hygiene when distributing and serving food.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
*.		085033	B. WIN			C 04/05/2012	
	ROVIDER OR SUPPLIER			5€	EET ADDRESS, CITY, STATE, ZIP CODE 551 LIMESTONE ROAD /ILMINGTON, DE 19808	1	JJ/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	,	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 371		distribute and serve food	F	371	The Staff Development Coordinator or designee wis service Nursing staff on prohand hygiene when distributed and serving food.	per	5/16/
	by: Based on an obse observation of the it was determined the and distribute food the Stratford Dining On 3/28/12, during the Stratford Dining observed removing E21 went to the traitems, lifted the traitems.	NT is not met as evidenced rvation made during the dining funch meal and staff interview, hat the facility failed to serve under sanitary conditions in Room. Findings include:  the luncheon observation in Room, E21 (CNA) was a tray from a dining table, sh can to discard used paper sh can lid with her bare hands to the cart to get another			The ADNS or designee will complete random weekly a for three months to evaluat proper hand hygiene when distributing and serving for Results of these audits will forwarded to Quality Asses and Assurance for review a action as appropriate. The Quality Assessment and Assurance Committee will determine further audits ar action plans.	udits e od. be ssment and	1/2
F 372 SS=D	confirmed that she hand sanitizer after her bare hands, configured by the bare hands and sanitizer in order to the bare sanitizer in the bare sanitizer after the bare sanitizer in	d to speak with E21. E21 did not wash her hands or use r lifting the trash can lid with infirming the observation. Also, owed the surveyor that she had ne of her pockets. OSE GARBAGE & REFUSE spose of garbage and refuse	F	372	F372 – Dispose Garbage & Refuse Properly It is the practice of the facilit dispose of garbage and refus properly and to ensure comp is covered to prevent pest harborage.	ty to se	
	This REQUIREME by:	NT is not met as evidenced			The facility refuse compact	or	
FORM CMS-2	J 567(02-99) Previous Version	s Obsolete Event ID: AO8Z11	   	Fac	was repaired to prevent pes	·	et Page 9 of 14

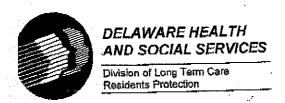
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	•				С	
		085033	B. WING _	- Prince Laboures	04/05/2012	
	ROVIDER OR SUPPLIER	VICES - PIKE CREEK	!	REET ADDRESS, CITY, STATE, ZIP CODE 5651 LIMESTONE ROAD WILMINGTON, DE 19808		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	
F 372	Based on observa	ations on 3/28/12, it was e facility failed to maintain the outside the facility in good	F 372	The Maintenance Director of designee will monitor/audit garbage and refuse compact the facility for compliance.	the 5/./	
	outside dumpster I provides harborag On 3/28/12 in an ir Director), he confir	3/28/12 revealed, that the id had a two inch gap. This e for unwanted pests.  Interview with E10 (Maintenance med the above finding.		The Maintenance Director of designee will complete week random audits for three more of the facility's refuse complete evaluate proper disposal methods and whether covers	kly nths pactor	
F 431 SS=E	The facility must e a licensed pharma of records of recei controlled drugs in accurate reconcilia records are in order controlled drugs is reconciled.  Drugs and biologic	DRUG RECORDS, RUGS & BIOLOGICALS  mploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an ation; and determines that drug er and that an account of all maintained and periodically eals used in the facility must be noce with currently accepted	F 431	provides prevention of pest harborage.  Results of these audits will forwarded to the Quality Assessment & Assurance Committee for review and as appropriate. The Quality Assessment & Assurance Committee will determine t	be action	
	professional princi appropriate access instructions, and the applicable.  In accordance with facility must store locked compartme controls, and permetave access to the The facility must p	ples, and include the sory and cautionary ne expiration date when a State and Federal laws, the all drugs and biologicals in nts under proper temperature int only authorized personnel to		need for further audits and/e action plans.  F431 – Drug Records, Label/Store Drugs & Biologicals It is the practice of the facil label and store drugs and biologicals according to cur accepted professional princ	lity to 5/16/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		085033	B. WING_	<del>-</del>	C 04/05/2012	
	ROVIDER OR SUPPLIER	VICES - PIKE CREEK		REET ADDRESS, CITY, STATE, ZIP CODE 5651 LIMESTONE ROAD WILMINGTON, DE 19808		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	N
F 431	Comprehensive D Control Act of 197 abuse, except who package drug dist quantity stored is r be readily detected	sted in Schedule II of the rug Abuse Prevention and 6 and other drugs subject to en the facility uses single unit ribution systems in which the minimal and a missing dose can	F 431	Facility immediately dispose the PPD/Tuberculin skin test solution on the Second Floor Arcadia/Heritage Unit.  An audit of all medication storage areas was completed evaluate the proper labeling storage of PPD/Tuberculin stest solution.	to and	
	by: Based on observated determined that the theorem and biological produces and biological produces are the through the throug	ation and interviews, it was e facility failed to ensure that ogicals that were stored in the rators were not expired.		The Staff Development Coordinator or designee will service nursing staff on prop storage and labeling of PPD/Tuberculin test solution	er	
	refrigerator on the there was one ope (PPD/Tuberculin S date as to when it insert for this med this medication mu	Skin Test) which did not have a had been opened. Package ication states that once open, ust be discarded within 30 days.  4/2012 with E23 (nurse)		The Director of Care Delivery designee will complete rando weekly audits for three month evaluate whether PPD/Tubero test solutions are labeled, storproperly and disposed of by the expiration date.	m ns to culin red	
	refrigerator on the there was one ope (PPD/Tuberculin Stwo open vials of A on them for when Package insert for	on 4/4/2012 of the medication second floor revealed that en vial of Aplisol Skin Test) dated 2/5/2012 and Aplisol that did not have a date they had been opened. this medication states that edication must be discarded		Results of these audits will be forwarded to the Quality Assessment and Assurance Committee for review and act as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or	ion	13.

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		085033	B. WING_		C 04/05/2012	
	PROVIDER OR SUPPLIER	/ICES - PIKE CREEK	5	REET ADDRESS, CITY, STATE, ZIP CODE 651 LIMESTONE ROAD VILMINGTON, DE 19808	04/03/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLÉTION	
F 431	Continued From pa	ge 11	F 431			
F 441 SS=E	confirmed above fir 483.65 INFECTION SPREAD, LINENS  The facility must es Infection Control Property and to help prevent the of disease and infection Control The facility must estend to help prevent the of disease and infection Control The facility must estend to Infection Control The facility must estend to Infection Control The facility must estend to Infection	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction.  Il Program stablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections.  In add of Infection in Control Program esident needs isolation to of infection, the facility must interest and corrective infections.  It prohibit employees with a case or infected skin lesions with residents or their food, if cansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F 441	F441 Infection Control, Prevent Spread, Linens It is the practice of the facility establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent development and transmission disease and infection.  Facility contracted employee have current PPD/Tuberculin skin test.  E22 was in-serviced on propicleaning of an accu-check machine.  Housekeeping and Food Ser Directors completed audits of employee files to evaluate the employees have current PPD/Tuberculin skin testing place.	the 5/ n of //2 s of er vice of nat	
	(c) Linens Personnel must ha	ndle, store, process and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		085033	B. WING		1 .	C )5/2012
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES - PIKE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE  5651 LIMESTONE ROAD  WILMINGTON, DE 19808			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	infection.  This REQUIREMI by: Based on observ review, it was determinated infection provide a safe, safe environment, and development and infection. Findings  1. Review of facility that three staff our receive their Tuberthey were first him (Dietary Aide) with E18 (Director of Nu. 2. On 4/5/2012, these E2 (Director of Nu. 2. On 4/3/12 at 11 made of E22 (Nu. with an Accu Che	ENT is not met as evidenced ation, interviews and record ermined that the facility failed to control practices designed to nitary and comfortable to help prevent the transmission of disease and sinclude:  ty employee records revealed to f twelve reviewed did not erculin Skin Test (PPD) when ed. These employees were: E17 in a date of hire of 9/27/2011, i) with a date of hire of 9 (Housekeeping Staff) with a 0/2012.	F 441	The Staff Development Coordinator or designee w service the Housekeeping a Food Service Directors that employees are required to two-step PPD/Tuberculin a test.  The Housekeeping and For Service Directors will come random monthly audits for months to evaluate employ files for evidence of two-seppen for evidence of two-seppen for evidence of two-seppen for evidence audits forwarded to the Quality Assessment & Assurance Committee for review and as appropriate. The Quality Assessment & Assurance Committee will determine need for further audits and	and at new have a skin  od aplete 6 /ee tep apon  will be action ty the	5/16/12
	E22 then proceed machine with an a put the machine the drawer when the	d the Accu Check on R353.  led to clean the Accu Check alcohol wipe. She was about to back in the medication cart surveyor asked her what she Accu Check machine? E22		action plans.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		085033	B. WIN			   04/0	C 05/2012	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES - PIKE CREEK			<b></b>	56	ET ADDRESS, CITY, STATE, ZII 51 LIMESTONE ROAD LMINGTON, DE 19808			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	After being questicused, E22 then prodisinfect the Accurate wipe which she has stated that she has tated that she clewith each resident bleach wipes.  The facility failed to Program designed development and infection by impropressions.	vas an alcohol wipe.  oned about the alcohol wipe she oceeded to appropriately Check machine with a bleach d on the medication cart. E22 d ruined a couple of tops with h the past. Additionally, E22 ans the Accu Check machine use and usually uses the  o maintain an Infection Control to help prevent the transmission of disease and perly cleaning the Accu Check lcohol wipe. On 4/3/12, E22	F	141				



DHSS - DETUKE 3 Mill Road, Suite 308 Wilmington, Delaware 19806 (302) 577-6661

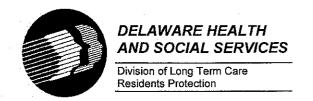
STATE SURVEY REPORT

Page 1 of 2

ARE AUDVEY COMPLETED: April 5, 2012

SECTION	TY: Manor Care Pike Creek  STATEMENT OF DEFICIENCIES  Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
		DATES TO BE CORRECTED.
	The State report incorporates by reference and also cites the findings specified in the Federal report.	
	An unannounced annual and complaint survey was conducted at this facility from March 28, 2012 through April 5, 2012. The deficiencies contained in this report are based on	
	observations, interviews, review of resident's clinical records and review of other documentation as indicated. The facility census the first day of the	
	survey was 159. The survey sample included forty (40) census sample residents and thirty (30) admission sample residents in Stage I. The Stage II sample totaled thirty eight (38) residents.	
3201	Skilled and Intermediate Care Nursing Facilities	2.
3201.1.0	Scope	
3201.1.2	Nursing facilities shall be subject to all applicable local, state and federa code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 hereby referred to, and made part to	State Cross refer to CMS 2567-L survey date completed 4/5/12, F225, F253, F323, F371, F372, F431 and F441.

Provider's Signature



DHSS - DLTCRP 3 Mill Road, Suite 308 Wilmington, Delaware 19806 (302) 577-6661

#### STATE SURVEY REPORT

Page 2 of 2

NAME OF FACILITY: Manor Care Pike Creek

DATE SURVEY COMPLETED: April 5, 2012

	* <sup></sup>	,
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	à	DATES TO BE CORRECTED
	this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.	5/16/12
	This requirement is not met as evidenced by:	
	Cross refer to CMS 2567-L survey date completed 4/5/12, F225, F253, F323, F371, F372, F431, F441	
		Sec.
		·
		<b>A</b> <sub>2</sub> ;
1		1